Disclosure

• Relationship with commercial interests: None

• Professional roles:
  – Addictions physician, Complex Pain & Addiction Service, VGH
  – Medical consultant, Prescription Review Program
Objectives

By the end of this talk participants will be able to:

- Describe the individual and public health harms associated with increased prescription opioid use
- Appreciate the rationale for the College’s Safe Prescribing Standards and Guidelines of Drugs with Potential for Misuse/Diversion
- Access resources for complex patients
Scope of the problem

Public health harms
'Too toxic to touch': Police struggle to deal with fentanyl

'We're simply not going to arrest our way out of this problem. It's too big an issue'

By Eric Renner, CBC News  |  Posted: Sep 16, 2016 2:00 AM PT  |  Last Updated: Sep 16, 2016 9:33 AM PT

POINT OF VIEW | The new face of fentanyl addiction:

'I just couldn’t stop,’ 22-year-old says

By Eric Renner, CBC News  |  Posted: Sep 17, 2016 2:00 AM PT  |  Last Updated: Sep 17, 2016 8:55 AM PT

Fentanyl deaths are a Canada-wide 'disaster'

A mysterious narcotic is hundreds of times more powerful than heroin


Fentanyl involved in at least 32 Maritime drug deaths

Experts warn that the fentanyl crisis, which has killed hundreds in British Columbia, could be coming east

By Karen Serton, Angus MacDonald, CBC News  |  Posted: Sep 14, 2016 8:30 AM ET  |  Last Updated: Sep 14, 2016 8:30 AM ET
Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2015

Deaths per 100,000 population

Any Opioid

Heroin

Natural & Semi-Synthetic Opioids

Other Synthetic Opioids (e.g., fentanyl, tramadol)

Methadone

Figure 2  Proportion of all deaths that are opioid-related, by age group, 1992, 2001 and 2010. The proportion of deaths in each age group that involved an opioid was calculated using opioid-related death data abstracted from the Office of the Chief Coroner of Ontario and deaths from all causes identified using the Ontario Registered Persons Database. This analysis was performed at three time-points over our study period: 1992, 2001 and 2010.
Prescription opioid analgesics (POA)

- Increase in opioid prescriptions has led to:
  - ↑ overdoses
  - ↑ ED visits for non-medical POA use
  - ↑ neonatal abstinence syndrome
  - 900% ↑ in individuals seeking addiction treatment for POA addiction (US data)

80% of heroin users report their use began with POA

SAMHSA 2013
Scope of the problem

Individual harms
Management of chronic pain with opioids is “a perfect storm of controversy...”

—Dr. Scott Fishman
“A perfect storm of controversy...”

“... a War on Pain and a War on Drugs” — Dr. Scott Fishman

- Pain management
- Iatrogenesis
- Addiction
- Diversion
Safe Prescribing of Drugs with Potential for Misuse/Diversion

College’s Position

The public health crisis of prescription drug misuse has developed in part due to the prescribing of physicians. The profession has a collective ethical responsibility to mitigate its contribution to the problem of prescription drug misuse, particularly the over-prescribing of opioids, sedatives and stimulants.
Safe Prescribing of Drugs with Potential for Misuse/Diversion

College’s Position

The public health crisis of prescription drug misuse has developed in part due to the prescribing of physicians. The profession has a collective ethical responsibility to mitigate its contribution to the problem of prescription drug misuse, particularly the over-prescribing of opioids, sedatives and stimulants.

The College acknowledges the appropriate role of pharmacotherapy in the context of active cancer, palliative, nursing home and end-of-life care. These standards may not apply to the treatment of patients in these situations.

Every physician is professionally responsible for the prescription that they provide to a patient.
latrogenesis
Dose-related risk of opioid overdose

Risk of adverse event

Risk Ratio

Dose in mg MED

<20 mg/day
20-49 mg/day
50-99 mg/day
>=100 mg/day

Dunn 2010
Bahnert 2011
Gomes 2011
Zedler 2014

Courtesy
Gary Franklin
Safe Prescribing of Drugs with Potential for Misuse/Diversion

Standards

Physicians **must:**

5. Always prescribe the lowest effective dosage of opioid medication. Doses >50 morphine milligram equivalents (MME) per day warrant careful reassessment and documentation. Doses >90 MME per day warrant substantive evidence of exceptional need and benefit. (This advice excludes treatment with methadone.)
Overvaluation of therapeutic effects?

“The explosive use of therapeutic opioids, however, is complicated by a lack of evidence regarding their effectiveness, long-term efficacy, and safety data in the treatment of chronic non-cancer pain, but there is irrefutable evidence of adverse consequences (46, 54-123)”
Evidence of LT effectiveness of POA for CNCP is lacking whilst evidence for risk of harm is plentiful

- Respiratory depression
- CNS depression
- Dysphoria and MDD
- Falls
- H-P-G and H-P-A axis dysfunction
- **Increased pain sensitivity (OIH)**
- Gastroparesis
- Xerostomia
- Immunosuppression
Safe Prescribing of Drugs with Potential for Misuse/Diversion

Guidelines

6. Other concurrent medical conditions which should be carefully considered in the context of decisions to prescribe or continue LTOT include obesity, congestive heart failure, sleep apnea, chronic lung disease and renal or hepatic insufficiency. Elderly patients are more likely to suffer from these concurrent diagnoses and to be taking multiple medications and suffer from cognitive impairment all of which significantly increase risk.
Trends and sex differences in prescription opioid deaths in British Columbia, Canada

Emilie J Gladstone, Kate Smolina, Steven G Morgan

- Between 2004 and 2013 there were 3,775 drug poisoning-related deaths and prescription opioids were involved in 1,674 of these
- The majority of prescription opioid deaths were secondary to opioids other than methadone (methadone was involved in 25% of deaths)
- Men experienced higher mortality rates than women
- The majority of prescription opioid deaths were unintentional (73% for women; 82% for men)

Safe Prescribing of Drugs with Potential for Misuse/Diversion

Standards

Physicians must:

9. Document the offer of a take-home naloxone prescription to all patients who are at risk of respiratory depression as a consequence of receiving opioid medications.
Combinations
Benzodiazepines: A Major Component in Unintentional Prescription Drug Overdoses With Opioid Analgesics

- During 2003 to 2009 the two prescription drugs with the highest increase in death rates were oxycodone (265%) and alprazolam (234%)
- Benzodiazepines involved in >5500 deaths in 2009 (5-fold increase since 1999)
- ED visits in the US for nonmedical use of BZD between 2004 and 2010 increased by 139%
- The opioid and BZD combination had the highest predicted model for drug-related fatality
Opioids + benzodiazepines/sedatives

- 40 to 60% of chronic pain patients concurrently use BZD
- Concurrent BZD use is high in patients on opioid maintenance treatment (~50%)
- Co-administration of BZD with an opioid increases subjective ratings of “strength,” drug “liking,” and “high” from the opioid

Opioids + BZD/sedatives = complications

- Respiratory depression → overdose
- CNS depression
- Increased psychiatric comorbidity
- Increased risky behaviours
- Daytime somnolence → Increased risk MVA, workplace injury
- Cognitive disturbance
- Balance disorder
- Addiction
BZD implicated in as many as 80% of unintentional overdoses involving opioids
11. The advice to avoid concurrent prescribing of opioids and sedative hypnotics such as benzodiazepines is based on the significantly increased risk of overdose death in this patient population. However, physicians should be aware that other central nervous system (CNS) depressants (including muscle relaxants, anticonvulsants, sedating antidepressants, antipsychotics, some over-the-counter medications and alcohol) may also potentiate CNS and respiratory depression. If LTOT is clinically appropriate, benzodiazepines should be tapered and discontinued. Benzodiazepine tapering should be gradual because of the significant risks of benzodiazepine withdrawal.
Addiction
Previous understanding: Separate silos

Chronic pain

Addiction
Current understanding: Intersection

- Chronic pain
- Addiction

Intersection of Chronic pain and Addiction
Spectrum of chronic pain and addiction
Spectrum of chronic pain and addiction

85y spinal stenosis, No SUD/psychiatric hx
Stable dose opioids 10 years

22y fibromyalgia; AUD as teen, Bipolar, FHx addiction,
Escalating opioid doses, lost Rx

Chronic pain

Addiction
Spectrum of chronic pain and addiction

85y spinal stenosis, No SUD/psychiatric hx
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Escalating opioid doses, lost Rx
Spectrum of chronic pain and addiction

50y chronic abdo pain, chronic pancreatitis, AUD 25y remission, FHx depression, opioid doses ↑ slowly
Spectrum of chronic pain and addiction

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Original Research

Prescription Medication Obtainment Methods and Misuse

Daniel Tyler Boulard, MD, Eric Fine, MD, David Withers, MD, and Margaret Jarvis, MD

- Small survey (n=36) Inpatient addiction program
- 75% had contrived symptoms including fake MRIs to demonstrate pathology, fake prescription bottles
- 8.3% physically harmed themselves to obtain Rx

- 66.7% stated intervention may have changed their behaviours and 61.1% would have welcomed an empathetic intervention by their physician
Safe Prescribing of Drugs with Potential for Misuse/Diversion

Guidelines

5. The prevalence of an opioid use disorder may be as high as 26% among primary care patients receiving opioids for CNCP. Patients with a diagnosis of an opioid use disorder should be offered treatment including medication assisted treatment with methadone or buprenorphine, as well as abstinence-based treatment where appropriate.
Diversion
Sources of prescription opioids for those that abuse them (Adapted from SAMHSA 2010)

- Free from friend or relative: 56%
- Purchased from friend/relative: 17%
- Drug dealer/stranger: 11%
- Prescribed by one doctor: 7%
- Taken from friend/relative without asking: 4%
- Other source: 5%
Table 1
Sources of pain relievers, stimulants, and tranquilizers, and when they were used.

<table>
<thead>
<tr>
<th>Source of drugs</th>
<th>Pain relievers (%)</th>
<th>Stimulants (%)</th>
<th>Tranquilizers (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A friend gives them the drugs</td>
<td>59.6</td>
<td>78.6</td>
<td>60.5</td>
</tr>
<tr>
<td>Own prescription</td>
<td>32.7</td>
<td>21.4</td>
<td>13.2</td>
</tr>
<tr>
<td>Family member provides them</td>
<td>26.9</td>
<td>11.4</td>
<td>28.9</td>
</tr>
<tr>
<td>Purchases them from a friend</td>
<td>17.3</td>
<td>41.4</td>
<td>18.4</td>
</tr>
<tr>
<td>Purchases them from an acquaintance</td>
<td>9.6</td>
<td>14.3</td>
<td>7.9</td>
</tr>
<tr>
<td><strong>Reason for use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Studying for final exams</td>
<td>8.2</td>
<td>65.7</td>
<td>9.1</td>
</tr>
<tr>
<td>Studying for midterm exams</td>
<td>6.1</td>
<td>54.3</td>
<td>9.1</td>
</tr>
<tr>
<td>Studying for regular exams</td>
<td>6.1</td>
<td>48.6</td>
<td>9.1</td>
</tr>
<tr>
<td>Before attending class</td>
<td>2.0</td>
<td>31.4</td>
<td>12.1</td>
</tr>
<tr>
<td>Socializing and partying</td>
<td><strong>69.4</strong></td>
<td><strong>47.1</strong></td>
<td><strong>48.5</strong></td>
</tr>
<tr>
<td>Self-medication*</td>
<td>24</td>
<td>N/A</td>
<td>97</td>
</tr>
</tbody>
</table>

* Includes pain relievers used for self-medication of pain/sleep, and tranquilizers used for self-medication of anxiety and to aid in relaxation. Participants did not list any uses for stimulants that were for self-medication, rather, the principle reason for using stimulants was for studying purposes, as indicated above.

A survey of nonmedical use of tranquilizers, stimulants, and pain relievers among college students: Patterns of use among users and factors related to abstinence in non-users

Sara A. Brandt, Elise C. Taverna, Robert M. Hallock
Safe Prescribing of Drugs with Potential for Misuse/Diversion

Standards

Physicians must:

8. Base decisions to prescribe long-term psychoactive medications, including LTOT, on well-documented, comprehensive initial assessments and frequent (at least every three months) reassessments. These assessments and reassessments must include documented history and physical examination of the patient. There must also be documentation that the patient has been screened regularly for the presence or emergence of mental health and substance use disorders and risk factors and advised about safety-sensitive occupational risks, child care responsibilities and driving.

Further, physicians must not:

14. Provide prescriptions allowing dispenses of opioids, sedatives and stimulants, which exceed a three-month supply or 250 tablets, whichever is less.
Urine drug testing and checking PharmaNet: Objective tools as part of clinical assessment

• Study to identify/quantify rate of aberrant drug-taking behaviours using objective data in a university-based, multidisciplinary pain centre
• Interview, questionnaire (prescription, illicit, OTC Rx), UDT
• Discrepancies between patient report, PDMP, referring physician records and UDT were reported to provide an overall Inconsistency Score (IS) (Max points 16)
• Addition of UDT or PDMP to patient questionnaire and referring physician records increased identification of inconsistencies by 400%
• **Addition of UDT and PDMP to patient questionnaire and referring physician records increased identification of inconsistencies by 900%**

Hamill-Ruth RJ et al.Pain Medicine 2013;14:1900-1907
Safe Prescribing of Drugs with Potential for Misuse/Diversion

Standards

Physicians must:

1. Review patients’ current medications (using PharmaNet profiles when access is available) before prescribing opioids, sedatives or stimulants.

11. Order at least annual random urine drug testing (rUDT) and/or random pill counts for all adult patients on long-term opioids, benzodiazepines, sedative hypnotics or stimulants.
Resources
Managing difficult conversations

**TABLE 1**

*Initiating chronic opioid therapy: recommended steps*

<table>
<thead>
<tr>
<th>Step</th>
<th>Details</th>
</tr>
</thead>
</table>
| Express empathy, partner with your patient| Empathy signals that the provider has the patient’s best interests in mind
Expressing empathy does not commit the provider to prescribing opioid therapy |
| Optimize nonopioid therapy                | Utilize nonpharmacologic treatments, adequately dose nonopioid analgesics, and use disease-modifying therapy when appropriate, typically in combination |
| Frame the treatment plan as a therapeutic trial | Opioids should only be continued:
If safe and effective
At the lowest effective dose, and
As one component of a multimodal pain treatment plan |
| Target functional goals                   | Treatment goals should be based on functional improvement, not pain reduction
A useful mnemonic to help identify such goals is SMART: specific, measurable, action-oriented, realistic, and time-bound |
| Obtain informed consent, document thoroughly | Communicate risks, potential benefits, and safe medication-taking practices, including safe storage and disposal of unused opioids
Document this conversation clearly in the medical record |
| Employ safe, rational pharmacotherapy     | Consider opioid potency, onset of action, and half-life when choosing a medication
Comorbid conditions and concurrent prescriptions should affect choice of formulation, dosage, and rapidity of titration
Methadone accumulates in adipose tissue and needs to be up-titrated slowly |

Prescribing opioids in primary care: Safely starting, monitoring, and stopping
**Discontinuing opioids: Do’s and don’ts**

<table>
<thead>
<tr>
<th>Do</th>
<th>Don’t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frame the discussion in terms of safety and efficacy, consistent with the treatment agreement</td>
<td>Debate your decision with the patient</td>
</tr>
<tr>
<td>Present your reasoning in a considered manner</td>
<td>Use accusatory or blaming language</td>
</tr>
<tr>
<td>Focus on the treatment and the patient’s response to it</td>
<td>Focus on the patient’s character or use labels (e.g., “drug addict”)</td>
</tr>
<tr>
<td>Emphasize your commitment to the patient’s well-being and details of the new treatment plan (i.e., nonabandonment)</td>
<td>Abandon the patient</td>
</tr>
<tr>
<td>Respond to emotional distress with empathy</td>
<td>Allow empathy to change your decision on discontinuation</td>
</tr>
</tbody>
</table>
Watch the Dr. Mike Evans video (and get your patients to watch it too!)

Currently at: https://www.youtube.com/watch?v=7Na2m7Ix-hU

**Opioids Videos**

Posted by admin on Mar 19, 2013 in Videos | 1 comment

Here are our Opioid videos in English and French!
Must read!

  – How to talk to patients about the risks of chronic opioid therapy (COT)
  – Strategies for mitigating risk in patients already receiving COT
  – Strategies for mitigating risk when discontinuing COT
Province-Wide Addiction Services
Available on the RACE line
Telephone advice for:
- family physicians
- community specialists
- nurse practitioners

RACE provides:
- An opportunity to speak directly with addiction medicine specialists
- Timely guidance and advice for patients with substance use disorders
- Expert advice on managing substance use disorders including:
  - Pharmacological management of opioid use disorders including buprenorphine/naltrexone inductions
  - Alcohol relapse prevention medications
  - Alcohol withdrawal management

Learning opportunity
Enhanced ability to manage the patient in your office
Calls returned within 2 hours and commonly within an hour
CME credit through the College of Family Practice website: www.cfpc.ca

BILLING CODES
Family Physicians
G14018 General Practice Urgent Telephone Conference with a Specialist Fee: $40.00
Specialists
G10001 Specialist Telephone Advice - Response within 2 hours: $60.00
G10002 Specialist Telephone Patient Management
  - Initiated by a Nurse Practitioner - per 15 minutes or portion thereof: $40.00
Bounce Back®: For adults and youth

Bounce Back® teaches effective skills to help individuals (aged 15+) overcome symptoms of mild to moderate depression or anxiety, and improve their mental health. Participants can learn skills to help combat unhelpful thinking, manage worry and anxiety, and become more active and assertive.

https://www.cmha.bc.ca/programs-services/bounce-back/
Chronic Pain Management Conference

• Come to our excellent annual CME event